Services Integration

Overview Paper 6

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment
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EXECUTIVE SUMMARY

This overview paper defines and explains services integration and differentiates services integration from systems integration. Services integration refers to the process of merging previously separate clinical services at the level of the individual to meet the substance abuse, mental health, and other needs of persons with co-occurring disorders (COD). The paper examines issues concerning the context, content, approaches, and processes that promote and inhibit services integration.

Persons with COD are, by definition, persons with multiple service needs. COCE takes the position that

> The interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly. It is a disservice to the person with COD to emphasize attention to one disorder at the expense of the other. (See COCE Overview Paper 3, *Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*, p. 4).

Effective treatment of persons with COD can only occur when mental health and substance abuse services are, at least to some degree, integrated. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or a program that provides appropriately integrated services by all clinicians or teams to all clients. The message should always be clear that staff members will do their best to help people with all their problems.

LITERATURE HIGHLIGHTS

The need for integrated services for persons with COD is apparent in the high community rates of COD (Grant et al., 2004; Kessler et al., 1994; Regier et al., 1990), the negative impact of one untreated disorder on recovery from the other (Rosenthal & Westreich, 1999), and the fact that most treatment settings are unprepared to effectively manage both substance use and mental disorders (SAMHSA, 2002). In the late 1990s, a four quadrant conceptual framework (National Association of State Mental Health Program Directors [NASMHPD] and National Association of State Alcohol and Drug Abuse Directors [NASADAD, 1998]) suggested the need for services integration for individuals with more severe substance use disorders and more severe mental disorders (Quadrant IV) (see also Overview Paper 1, *Definitions and Terms Relating to Co-Occurring Disorders*). Most available research has focused on the need for, and the effects of, services integration for those with severe substance use and mental disorders (e.g., Drake et al., 2001).

Little research has explored services integration for those with less severe disorders. Nonetheless, research supports the *principle* that services integration can play an important

Table 1: Key Definitions

Integration	As used in this paper, integration refers to strategies for combining mental health and substance abuse services and/or systems, as well as other health and social services to address the needs of individuals with COD.
Services Integration	Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients.
Dual Diagnosis Capable (DDC)	Programs that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (American Society of Addiction Medicine [ASAM], 2001, p. 362).
Dual Diagnosis Capable (DDE)	Programs that provide unified substance abuse and mental health treatment to clients who are, compared to those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder" (ASAM, 2001, p. 10).
Systems Integration	The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families.

role in providing appropriate and effective treatment to all persons with COD (SAMHSA, 2002). Current programs can be classified as having basic, intermediate, or advanced capacity for COD treatment, with the highest level being full integration of addiction, mental health, and related services (CSAT, 2005).

Accepted evidence-based practices such as Integrated Dual Disorders Treatment (Center for Mental Health Services, 2003), other forms of integrated treatment, and other promising models in both addiction and mental health settings have been developed as integrated service strategies for treating COD. For example, Assertive Community Treatment and cognitive–behavioral interventions have produced positive substance abuse outcomes for persons with COD (McHugo et al., 1999; Mueser et al., 2003), and research has identified specific pharmacologic treatments for specific pairs of co-occurring conditions (Noordsy & Green, 2003; Rounsaville, 2004).

KEY QUESTIONS AND ANSWERS

1. What is meant by "integration" and "integrated"?

The terms "integration" and "integrated" appear throughout the literature on COD: for example, systems integration, services integration, integrated care, integrated screening, integrated assessment, integrated treatment planning, integrated interventions or treatment, integrated models, integrated systems, integration continuum, and so on. The pervasiveness of "integration" and "integrated" in the language of COD reflects the following:

- The awareness that the co-occurrence of these disorders is not simply by chance and occurs frequently
- An understanding that there is always a relationship between the disorders that affects outcomes
- The recognition that effective responses to persons with either mental illness or substance use disorders are compatible

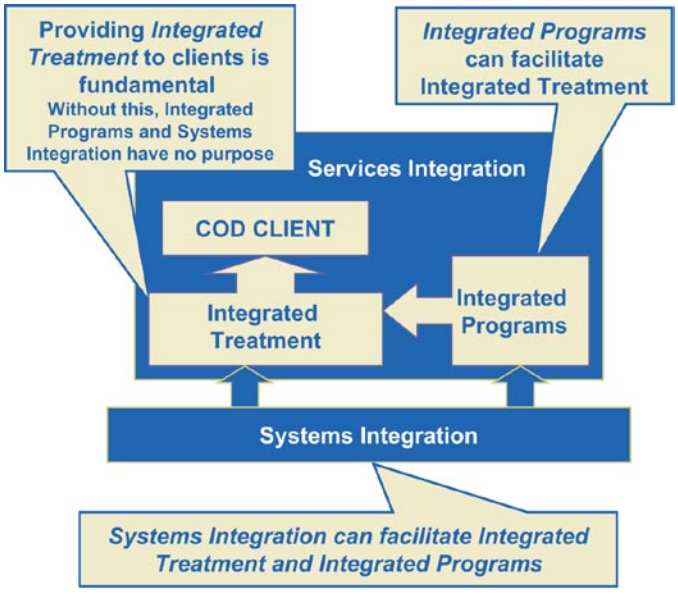
The various types of integration listed above refer to different service components (e.g., screening, assessment, treatment planning, treatment provision) or levels of the service system (e.g., individual practitioners, agencies, local systems of care, States). The specifics of what is to be integrated and the mechanisms by which integration is accomplished will, of course, be different for different service components and at different levels of care. The primary focus of integration is always the same—identifying and managing substance use and mental disorders and the interaction between them. Integration may also seek to identify and manage related health and social problems. The goal of all forms of integration is to support integrated treatment for the individual client.

2. What is services integration and how does it fit with other kinds of integration?

Services integration for COD (see Table 1) is defined as any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integration can be implemented by single providers, teams of providers, or entire programs. Accordingly, services integration can be thought of as having two levels (see also Figure 1):

- *Integrated Treatment,* which occurs at the level of the client–clinician interaction. (This level of integration might also be called "clinician-level" integration.) Integrated treatment can be provided across agencies, within a program, or in an individual provider's office (CSAT, 2005). Integrated treatment includes integrated assessment, active treatment, and continuing care, as well as concrete activities, such as reviewing explicitly with the client how he or she is dealing with any problem and following any set of recommendations.
- *Integrated Programs,* which are implemented within an entire provider agency or institution to enable clinicians to provide integrated treatment for COD. A COD-specific integrated program is organized to provide substance abuse, mental health, and sometimes other health and social services to persons with COD.

Figure 1: Services Integration and Other Forms of Integration



As shown in Figure 1, integrated treatment and integrated programs are supported and facilitated by systems integration. However, unless integrated treatment is provided to clients, other forms of integration serve no purpose. It is important to note that, although collaboration

among providers and programs is one important component of services integration, it is the content and structure of the collaboration that supports and facilitates integrated treatment.

3. *What are the benefits and challenges associated with integrated services from a programmatic, clinical, and consumer viewpoint?*

Given the high numbers of clients with COD seeking substance abuse or mental health services, failure to address COD in either substance abuse or mental health programs is tantamount to not responding to the needs of the majority of program participants. From this perspective, providing integrated services is fundamental to providing quality care.

Benefits. A core set of benefits of services integration to programs, clinicians, and consumers can be identified:

- Improved client outcomes (see Question 4)
- Improved adherence to treatment plans where both substance abuse and mental illness interventions are supported
- Improved efficiency because consumers do not have to shuffle between providers and clinicians do not have to make referrals and maintain communications among providers

Additional benefits to consumers include

- Better integrated information rather than conflicting advice from several sources
- Improved access to services through "one-stop shopping"

Additional benefits to programs and clinicians include

- Opportunities for agency and professional growth
- Workforce development
- Less frustration and increased job satisfaction

Challenges. From the perspective of the consumer, there are few, if any, disadvantages to services integration. From the perspective of programs and clinicians, implementation of integrated services involves many of the same challenges as any other form of organizational change and development. These may include the need to

- Identify and respond to gaps in workforce competencies, certifications, and licensure
- Proactively address staff concerns related to changes in roles and responsibilities
- Institute modifications in record keeping to accommodate COD
- Modify facilities to meet additional needs (e.g., space for individual or group counseling)
- Revise staffing patterns and work schedules
- Reconcile differences in confidentiality regulations, policies, and practices between substance abuse and mental health
- Revise policies, practices, and requirements regarding dispensing and managing medications
- Utilize new reimbursement sources and procedures

In-depth discussions of these and other issues related to managing organizational change are provided by Fixsen and colleagues (2005).

4. *What types of outcomes can be expected from services integration?*

Research evidence supports the claim that services integration leads to better client outcomes. For example, McLellan and associates (1998) report that clients receiving integrated services in addiction treatment settings are more likely to complete treatment and have better posttreatment outcomes. For clients with severe COD, integrated services have been shown to increase engagement in treatment and days of abstinence and reduce psychotic symptoms (Barrowclough et al., 2001; Drake et al., 1997, 2001; Hellerstein et al., 1995; Jerrell & Ridgely, 1995). For these clients, onsite integration may be *required* since delivery in multiple settings is associated with a rapid and significant decrease in treatment retention (Hellerstein et al., 1995).

A small but encouraging literature addresses the integration of primary care services with services for people with COD (Grazier et al,. 2003; Lester et al., 2004; Weisner et al., 2001). For example, individuals with substance-related medical or psychiatric conditions show a higher rate of abstinence in integrated substance abuse and primary care treatment than those receiving nonintegrated services (Weisner et al., 2001).

Models focusing on populations such as homeless or criminal justice clients have been developed through local advocacy. For example, there are housing programs that serve clients with COD with varying levels of treatment integration—including supportive housing programs that access COD services, contingency-managed access to housing, housing first models that provide services once clients have housing, and modified therapeutic communities where homeless shelter occupants receive onsite COD treatment (SAMHSA, 2005).

5. *How does one decide what services to integrate?*

Services integration *minimally* means providing integrated substance abuse and mental health screening, assessment, treatment planning, treatment delivery, and continuing care, either at the level of direct contact with the client or between providers or programs serving these individuals. Services integration is a process. Accordingly, any step to increase access to and coordination with the services needed by clients with COD is a step toward the ultimate goal of unifying service delivery and better outcomes for

persons with COD. Individuals with COD typically have a wide range of other health and social service needs (New Freedom Commission on Mental Health, 2003). Providers may need to help clients access general health services, HIV/AIDS services, legal aid, English as a second language classes, nutrition services, vocational rehabilitation, or employment assistance (SAMHSA, 2005). The choice of which services to integrate may be guided by practical considerations, program philosophy, stakeholder needs and concerns, or any other legitimate inputs into program decisionmaking.

In an ideal world, persons with COD would be provided "one-stop shopping" for all their substance abuse, mental health, medical, and psychosocial needs. From a practical perspective, perhaps the best rule is when a service need becomes apparent among a significant proportion of clients (e.g., housing services), the relevant services should probably be considered for integration. A "bottom-up" clinical approach can document the need for integrated services through comprehensive client assessment.

6. *Are there some services that should not be integrated?*

There is no reason, in principle, why any service that might be needed by a particular client population cannot be integrated with the provision of COD services. As discussed in Question 5, COD services have been successfully integrated with a variety of other health and human services.

7. *How are integrated services designed and implemented?*

The design and implementation of integrated services may depend on the severity of substance abuse and mental disorders in a specific population as well as their additional medical and psychosocial needs (see Question 5). The optimal integrated service design meets the clinical needs of people with COD with a treatment team that coordinates all pertinent aspects of care. Especially for those with serious disorders, an integrated service design co-locates that care (SAMHSA, 2002). Such an approach means that a range of services is provided, including provisions for medication management, case management, addiction counseling, and psychosocial rehabilitation.

Since most existing services are not proactively designed to take COD-specific service needs into account, integration usually requires a retrofit, with the addition of new services. One advantage to this approach is that programs can build on their current knowledge, skills, and strengths while expanding gradually (SAMHSA, 2003). Incremental approaches allow treatment facilities and providers to simplify and change licensing and certification requirements for treating COD in the context of different licensing and certification standards.

Other service strategies that facilitate integration include referral networks ("no wrong door"), physical and temporal proximity (e.g., services provided by the same clinician or in the same setting), and care coordination (e.g., services provided by a team of providers from different domains who take joint responsibility for the client).

With severe disorders, it is clearly advantageous to integrate mental health and substance abuse treatment programs into a unified, seamless service. In programs serving persons with less severe COD, integration may not need to be as comprehensive, as the full array of services may not be indicated for the population served (SAMHSA, 2005).

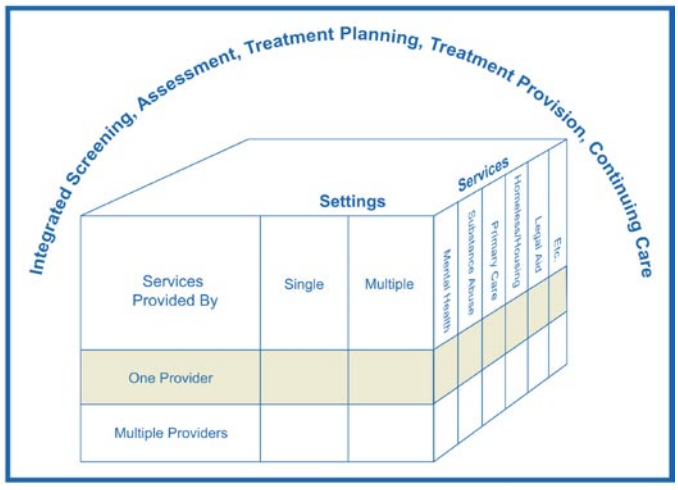
8. *What do integrated services look like in practice?*

There is no one organizational chart for services integration. Integrated services may be implemented using a wide variety of staffing configurations and agency formats that meet the overall goal of integrated screening, assessment, treatment planning, treatment provision, and continuing care.

As can be seen in Figure 2, any given service integration initiative can be defined by some combination of three components: (1) a set of services (minimally substance abuse and mental health) that are integrated, (2) whether services are integrated within or across settings, and (3) whether integrated services are provided by one or more providers.

So, for example, integration of substance abuse and mental health services can be accomplished when both types of services are provided by the same professional or when

Figure 2: Integrated Services



a substance abuse and mental health professional collaborate in the care of a client with COD. In the latter case, the substance abuse and mental health professionals can be located in the same setting or agency or in different settings. As one begins to consider services other than substance abuse and mental health, chances are that multiple providers and agencies will need to be involved.

The ASAM Patient Placement Criteria, Second Edition, Revised (ASAM, 2001) describes two levels of integrated programs for people with COD: Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE) (see definitions, Table 1). See also COCE Overview Paper 1, *Definitions and Terms Relating to Co-Occurring Disorders*.

In practice, the arrangement through which services integration is achieved will be dictated by local availability of services, fiscal feasibility, capacity to coordinate, and administrative support.

9. How does one set the context for services integration?

Services integration is the natural outgrowth of basic principles that form the foundation of COCE's approach to the care of persons with COD. Clear articulation of these principles and wide consensus among stakeholders regarding their importance are key steps toward setting the context for services integration. As noted in the Executive Summary, services for persons with COD must respond to the reality that "the interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly."

Organizations that articulate client-centered values, remove barriers, and allow staff to take appropriate risks and establish new relationships are vital for transforming services, including services integration. By contrast, rigidity, bureaucratic restraints, insufficient collegial support, change-averse culture, and demoralized staff will impede services integration (Corrigan et al., 2001). "Top-down" strategic decisions that are guided more by power structures, ingrained routines, and established resource configurations will inhibit services integration (Garvin & Roberto, 2001; Rosenheck, 2001).

Finally, workforce development is key to setting the context for services integration. Clinicians will profit from training in integrated screening, assessment, and treatment strategies for both mental and substance use disorders. Training in case management will facilitate coordination with other non-substance abuse or mental health services (McLellan et al., 1998).

10. What types of organizational structures and processes inhibit or promote services integration?

The implementation of services integration will face the same organizational challenges associated with implementing any new practice (see Fixsen et al., 2005). Strong leadership is key.

Some organizational issues are specific to services integration. An integrated organizational chart, shared assessment tools, and integrated policy manuals will facilitate the process of integrating services (NASMHPD & NASADAD, 1998). Services integration will be more difficult if there is a lack of funds for cross-training, lack of incentives for clinicians to cross-train, outdated policies that do not support COD treatment, and efforts at cost containment that impede the treatment of more severe disorders (SAMHSA, 2002). At the systems level, services integration is facilitated by regulatory guidelines that allow mental health and substance abuse funds to be combined or that provide specific guidelines and instructions for how to provide integrated treatment within the context of the existing funding mechanisms (Minkoff & Cline, 2004).

11. How can staff burnout in integrated settings be avoided?

Staff burnout presents a particular challenge in providing integrated services. "Compassion fatigue" may occur when the pressures of work erode a counselor's spirit and outlook and interfere with the counselor's personal life. To lessen the possibility of burnout when working with a demanding caseload that includes clients with COD, TIP 42 (*Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT, 2005]) recommends that clinicians providing COD services work within a team structure rather than in isolation, have opportunities to discuss feelings and issues with other staff who handle similar cases, be given a manageable caseload, and receive supportive and appropriate supervision.

12. What are the specific challenges to services integration from a substance abuse perspective?

The substance abuse professional or agency may have beliefs that must be addressed to implement integrated services. These include the belief that mental health problems are secondary to substance abuse and will improve when substance use is discontinued, and that medications should not be used with persons in recovery.

The specific responsibilities that staff in substance abuse agencies may undertake with clients depend on the licenses and/or certifications they hold. Licenses and certifications define the scope of practice for given disciplines, and

they differ by State and profession. All staff members can provide integrated services consistent with their licenses. For example, although substance abuse counselors in most States cannot treat mental disorders included in the DSM-IV-TR or prescribe medications for these disorders, they can monitor client behavior for signs that medication regimens are being followed and educate and motivate clients regarding the importance of taking their medications.

In addition, some issues associated with clients with mental disorders may be less familiar to substance abuse treatment providers. These include the symptoms of mental disorders; the overlap of these symptoms with those of addiction, intoxication, or withdrawal; and techniques for distinguishing mental disorders from substance abuse symptoms. Substance abuse treatment staff may also need to become more comfortable responding to key issues in recovery from mental disorders, such as the key role of medications and the importance of accepting partial recovery as a legitimate treatment goal for persons with severe mental health problems.

13. What are the specific challenges to services integration from a mental health perspective?

The mental health professional or agency may also have beliefs that must be addressed to implement integrated services, including the belief that substance abuse problems will resolve when mental disorders are addressed. In addition, some issues associated with clients with substance use disorders may be less familiar to mental health professionals. These include the common physical sequelae of substance abuse (e.g., HIV/AIDS, hepatitis) and the socio-legal issues that some clients face (e.g., court orders, conditions of release, probation, parole). Mental health staff may also need to become more comfortable responding to such substance abuse recovery issues as denial, working with a coerced client, abstinence, enabling, relapse, and peer counseling. Finally, from an agency perspective, mental health providers may find that reimbursement rates for addiction services are below rates for mental health services requiring comparable effort.

14. What should one do to convey to consumers that they are in an integrated services program?

For many consumers with a history of COD, entering an integrated service setting may be the first time they feel they are working with helpers who "get it" and who are not trying to put aside issues that the consumers know or sense are important. This feeling should be nurtured by developing an atmosphere that encourages a broad view of what the client may need and what the program can offer.

From initial contact and screening through continuing care, the consumer should feel that the program is responding to her or him as a whole person. This means that issues that are important to the consumer are important to the program and its clinicians. It also requires the program and clinicians to recognize and respect the complexities of the consumer's substance abuse, psychosocial, and health needs and to ensure they are prepared to address a variety of issues either in-house or through referrals.

FUTURE DIRECTIONS

Although there is scientific literature regarding the treatment of people with severe COD, there is little research-based guidance for the treatment of people with less severe COD (SAMHSA, 2003). Future research can inform the development of specific integrated interventions for specific combinations of substance use disorders and mental disorders, methods for integrating non-substance abuse or mental health services, and the development of integrated interventions for specific populations and service settings.

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